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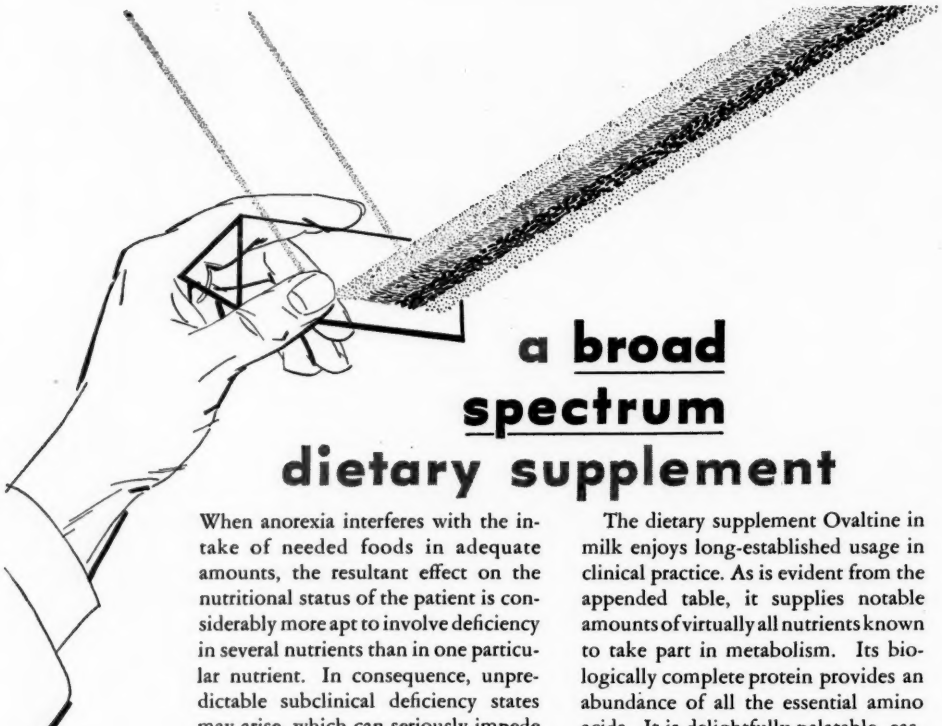

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The RHODE ISLAND MEDICAL JOURNAL

VOL. XXXVI FEBRUARY, 1953 NO. 2

THE PHYSIOLOGICAL EFFECTS OF OPERATIONS FOR DUODENAL ULCER*

REGINALD H. SMITHWICK, M.D.

The Author. *Reginald H. Smithwick, M.D., of Boston, Mass. Surgeon-in-Chief, Massachusetts Memorial Hospitals; Professor and Chairman of the Department of Surgery, Boston University School of Medicine.*

THE PHYSIOLOGICAL basis for operations for duodenal ulcer is to reduce the digestive power of the gastric juice to a point where peptic ulcer can no longer occur. The digestive power of the gastric juice is related to its content of hydrochloric acid and pepsin. Ideally, an operation should modify the digestive properties of the gastric contents sufficiently to give complete and permanent protection against further ulceration. In addition to the digestive properties of the gastric contents another factor, the capacity of the mucosa to resist ulceration, is also of unquestioned importance in the development of duodenal ulcer. This must vary greatly from patient to patient. As yet, no method has been devised for measuring this factor in each case. Consequently, it is necessary to modify the acid peptic factors in every case sufficiently to give protection to those patients having the lowest resistance to ulceration.

The question therefore naturally arises as to how much the acid peptic factor should be modified. There are two schools of thought in this regard. The first is exemplified by Wangensteen[1] who believes that achlorhydria to stimulation by histamine is desirable. The other is represented by Dragstedt[2] who feels that since duodenal ulcer patients secrete a larger quantity of hydrochloric acid per unit of time, particularly under fasting conditions of study, it is necessary only to reduce the amount of acid produced to within the normal range.

In recent years my associates and I have been obtaining more detailed information about the acidity of the gastric contents of ulcer patients than we have in the past. As a consequence we have reached the conclusion that it is not essential that an operation result in histamine achlorhydria since jejunal ulcers will heal promptly after secondary procedures which do not produce achlorhydria to this stimulus. Also, patients appear to be adequately protected against recurrent ulceration who do not have histamine achlorhydria after primary operations. It does, however, appear to be necessary that an operation result in achlorhydria under fasting conditions of study and in response to a potent food stimulus and to vagal stimulation as well. A potent food stimulus such as peptonized beef broth appears to be a better measure of the chemical phase of gastric secretion than histamine. The secretory response to food is much more readily abolished by operative procedures than is the response to histamine. To insist on histamine achlorhydria may result in unnecessarily radical surgical procedures. It seems much more logical to aim for achlorhydria to food stimulation since that is the manner in which the chemical phase of gastric secretion is activated in man. We have also reached the conclusion that it is necessary to do more than to reduce the quantity of hydrochloric acid produced per unit of time to within the normal range if one wishes to give adequate protection against recurrent ulceration.[3]

The method of study in use at the present time is a simplification of the much more detailed testing which was originally carried out.[4, 5] It appears to give the essential data and can be used in the routine evaluation of ulcer patients at a clinical level. In brief, a Levine tube is placed with the tip at the mid point of the stomach or gastric remnant under fluoroscopic control. Gastric juice is collected for one hour by continuous suction, the subject having fasted overnight. This is referred to as the basal test. Following this 80 cc. of peptonized beef broth are introduced into the stomach and aspirated at the end of twenty minutes. The gastric contents are again aspirated for a one hour period. This is referred to as the broth test. Fifteen units of regular insulin are then injected intravenously. Blood sugar levels are obtained before and at half-hour intervals over a two hour period following the administration of insulin. Gastric juice is aspirated by continuous suction until two one-hour samples

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*From the Departments of Surgery, Massachusetts Memorial Hospitals, and Boston University School of Medicine. Presented at the Fifth Annual Interim Meeting of the Rhode Island Medical Society held at the Ledgemont Country Club, Seekonk, Mass., on December 10, 1952.

are obtained. The free acid values for all four one-hour specimens are determined by electrometric titration to a pH of 3.5. When multiplied by the hour volume of gastric juice and divided by 1000 the milliequivalents of free hydrochloric acid are obtained. The pH of each specimen is also recorded. The specimen which contains the largest amount of acid following the injection of insulin is taken as the response to vagal stimulation. This is usually the second of the two one-hour specimens. This routine of study is completed in one morning and is performed by carefully trained and supervised technicians.

In addition to data concerning the acidity of the gastric contents the amount of pepsin in the gastric juice is also determined. This is a much more complex measurement and is not as yet developed to a point where it can be used as a routine clinical test. One can however infer from the acidity of the gastric contents what the per cent peptic activity will be. The relationship between peptic activity and pH is indicated by figure 1 and Table 1.

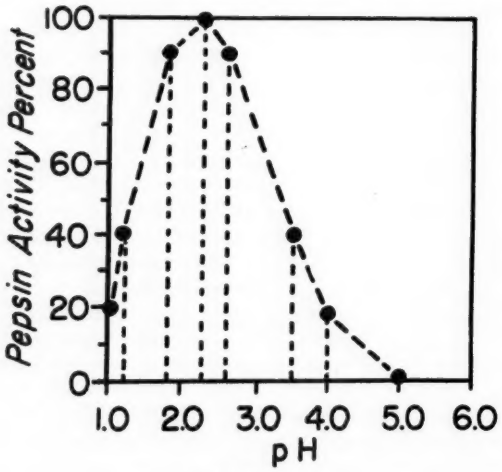

FIGURE 1

The relationship between pH and per cent pepsin activity in the digestion of gelatin. (Reproduced by permission of Hollander; Gastroenterology 4:497, 1945.)

It is of interest to discuss the data from this study in connection with failures of various surgical procedures. We have at this point studied the gastric contents of 17 patients who have developed gastrojejunal ulcers following various operations. In every instance, free hydrochloric acid was present under one or all of the conditions of study. In some cases, achlorhydria existed in the fasting state, but free hydrochloric acid was present on stimulation by broth and or insulin. Consequently the peptic activity of the gastric contents was presumably great enough to cause recurrent ulceration. In such cases the quantity of acid had been reduced to well within the normal range. Many patients will not develop recurrent ulceration in the presence of such low acid values and most patients who do develop jejunal ulcers have acid values which are only slightly lower than the levels prior to operation. This difference in the behavior of cases must be related to variations in the mucosal resistance factor. These findings again emphasize the fact that if one wishes to give patients maximal protection against recurrent ulceration the acid values in the gastric contents must be reduced not simply to within the normal range, but to the point of achlorhydria under fasting conditions of study and in response to stimulation by broth and insulin as well. We have yet to see a jejunal ulcer develop following an operation which produced these physiological effects. On the other hand, the operations performed in the 17 patients who developed recurrent ulceration failed to produce these effects in each instance.

TABLE 1

Acidity and Peptic Activity as Inferred from the Hydrogen Ion Concentration (pH) of the Gastric Contents

pH	*Acidity and Peptic Activity*
(a) Below 3.5	Free HCl present Peptic Activity 40%-100%
(b) 3.5 or more	Free HCl absent Peptic Activity 40%-0%

These findings have led us to take the position that the best results in the long run will in all probability follow those operations which consistently produce the physiological effects which have been discussed. Most recurrent ulcers develop in the early years following surgery. Some, however, do not make their appearance for as long as 25 years. Consequently a long follow-up of patients is important. This should be kept in mind especially when one is considering the choice of operation for the young or middle-aged patient requiring surgery for duodenal ulcer.

The early physiological effects of various operations for duodenal ulcer have been determined according to the method of study which has been described. While the number of cases in each group is small and the follow-up period too short to be significant, the findings are of interest. They are summarized in Table 2 in which the percentage of cases in each group having free hydrochloric acid in the gastric contents under one or more of the conditions of study as well as the percentage of cases having no free hydrochloric acid during all three tests is given. The results in the 17 gastrojejunal ulcer cases are included for comparison.

TABLE 2

Effects of Various Operations for Duodenal Ulcer upon Gastric Acidity as Judged by the Incidence of Achlorhydria under Fasting Conditions of Study and Following Stimulation by Beef Broth and Insulin

Operation	*No. Cases*	*Free HCl Present (pH below 3.5)*	*Free HCl Absent (pH 3.5 or more)*
Gastrojejunal Ulcers Following Various Operations	17	100%	0%
P.G.E. + Vagotomy	12	75%	25%
Gastrectomy ⅓ + Vagotomy	6	50%	50%
Gastrectomy ⅔-⅘	22	36%	64%
Gastrectomy ⅔-⅘ + Vagotomy	8	25%	75%
Hemigastrectomy + Vagotomy	40	7%	93%

A brief comment will be made upon each of the five groups of cases which are tabulated. In twelve patients, transabdominal vagotomy was combined with gastroenterostomy. In only three cases was free hydrochloric acid absent postoperatively under all conditions of study. These patients appear to have adequate protection against recurrent ulceration. Nine cases or 75% still have free hydrochloric acid under one or more conditions of study. We believe that it is in this group that recurrent ulceration is most likely to develop. These patients still have the capacity to develop ulcers and only time will tell how many will do so. Reports of recurrent ulceration following this combined procedure are beginning to appear in the literature even in early follow-up studies of much larger series of cases.[6] We can only suspect that the eventual recurrence rate will be too high to make this operation the procedure of choice especially in young and middle-aged individuals. We prefer to use this maneuver in very bad risk obstructed patients or in those in whom the management of the duodenal stump would make gastric resection a hazardous procedure.

In six cases the distal third of the stomach was removed in conjunction with resection of the vagus nerves. The purpose of this procedure was to evaluate its physiological effect upon the acidity and by inference, the peptic activity of the gastric contents since such a maneuver would eliminate both the nervous and the chemical phase of gastric secretion insofar as the antrum is implicated in the latter mechanism. The importance of the antrum in the chemical phase of gastric secretion has been emphasized for many years ever since Edkins first postulated that this area of the gastric mucosa has the capacity to elaborate a substance (gastrin) as a result of the ingestion of food. This substance is absorbed into the blood stream and in this manner reaches the parietal cells in the body and fundus of the stomach and stimulates them to secrete hydrochloric acid. This combined procedure should theoretically remove what are generally considered to be the two most important mechanisms for the production of hydrochloric acid. The physiological effect of this procedure seemed better than that of vagotomy combined with gastroenterostomy in that one-half of this small group of cases were achlorhydric under all conditions of study and presumably are therefore adequately protected against recurrent ulceration.

The next group of patients to be studied was a small series of 22 cases in whom subtotal gastrectomies were performed. The extent of resection varied. At least the distal two-thirds and at most the distal four-fifths of the stomach was removed. The results indicate that this procedure is more effective in rendering the gastric contents achlorhydric under all conditions of study than either of the previously mentioned operations since this state of affairs resulted in 64% of the patients. Subtotal gastrectomy has come to be considered the procedure of choice in the management of chronic duodenal ulcer problems requiring surgery. It has been utilized for many years and is regarded by many as the most effective procedure devised to date. To supplant subtotal gastrectomy, an operation must be proven to be superior to it on the basis of an adequate follow-up of an appropriate number of cases both on physiological and clinical grounds.

The next group of cases consists of eight patients who had developed gastrojejunal ulcers following subtotal gastrectomy and who subsequently had vagotomies performed. Following the combined maneuver, six or 75% of the cases were achlorhydric under all conditions of study. The combined maneuver was slightly more effective in producing achlorhydria than subtotal gastrectomy alone. The numbers of cases are too small to be conclusive. This suggestion that subtotal gastrectomy combined with vagotomy is physiologically more effective than subtotal gastrectomy alone is, however, abundantly confirmed by Colp et al[7] who have proven without doubt that this is the case by the comparative results in two large series of cases followed for an adequate period of time. In one, subtotal gastrectomy alone was employed. In the other, vagotomy was performed in addition to subtotal gastrectomy. In the eight cases under discussion, the jejunal ulcers healed promptly in seven. In two, the vagotomies were incomplete. These were the cases in which achlorhydria was not present under all conditions of study. In one of these, the jejunal ulcer failed to heal necessitating a secondary vagotomy. Following this, the patient became achlorhydric under all conditions of study as indicated by figure 2. There is little doubt that if a secondary

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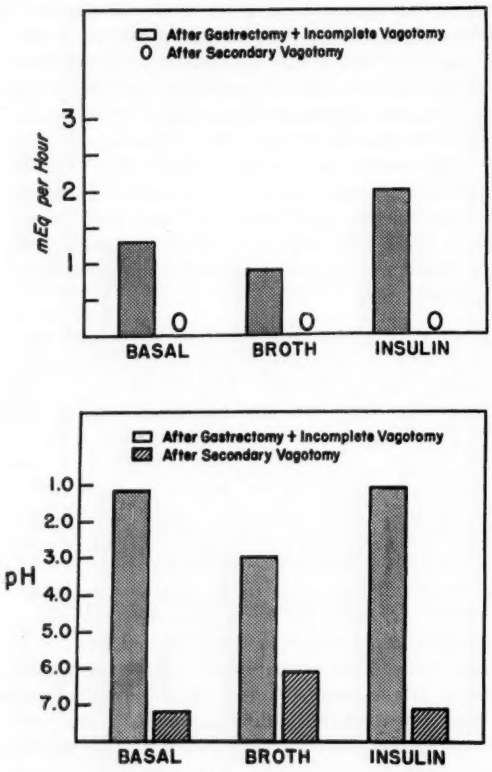

FIGURE 2

Acidity-Gastric Contents

Case with Gastrojejunal Ulceration Following Gastrectomy ¾ plus Incomplete Abdominal Vagotomy which Healed after Secondary Transthoracic Vagotomy

vagotomy was performed in the remaining case, that achlorhydria under all conditions of study would result. Theoretically subtotal gastrectomy combined with complete vagotomy should result in achlorhydria in something approximating 100% of cases.

The last group to be mentioned is a series of 40 cases in whom the distal one-half of the stomach was removed in combination with resection of vagus nerves. Ninety-three per cent of these cases had achlorhydria under all conditions of study. In the three cases who still had free hydrochloric acid in the gastric contents under one or more conditions of study the vagotomies were incomplete. These findings suggest that if the distal one-half of the stomach is removed in combination with vagotomy that the physiological effects closely approximate those following more radical resections of the stomach combined with vagotomy. Removing more than one-half of the stomach in combination with vagotomy does not appear to add much if anything to the physiological effects which follow hemigastrectomy and vagotomy.

This discussion has had to do primarily with the physiological effects of various operations for duodenal ulcer. The clinical results are also important. Excluding the problem of recurrent ulceration, there are many other untoward side effects of operations for duodenal ulcer which must be taken into consideration in the final evaluation of a particular procedure. Some are mild and some are severe. The principle side effects which concern us are listed in Table 3. We have the very definite impression that there is a close relationship between the size of the gastric remnant and the severity of the residual side effects. The smaller the gastric remnant the higher the incidence of untoward symptoms. Thus, the clinical results of radical subtotal gastrectomy alone or combined with vagotomy are not as good as those following gastroenterostomy or hemigastrectomy combined with vagotomy.[8] Since this latter procedure compares most favorably as regards the physiological effects with any other operation we have studied, and since the clinical results are superior to those following procedures involving the removal of a larger portion of the stomach, it is our present impression that hemigastrectomy combined with vagotomy is the operation which is most likely to supplant subtotal gastrectomy as the maneuver of choice in the management of duodenal ulcer problems requiring elective surgery.

TABLE 3

Untoward Side Effects of Operations for Duodenal Ulcer

1. Weight loss.
2. Loss of appetite.
3. Specific food intolerance.
4. Limitations in quantity of food intake.
5. Need for eating frequently.
6. Distress, fullness, regurgitation, nausea or vomiting after eating.
7. Dumping syndrome.
8. Need for restriction of tobacco, alcohol, coffee, etc.
9. Excessive belching or flatus.
10. Limited working capacity, physical or mental.
11. Modification of bowel function.
12. Need for diet or medication.
13. Secondary anemia.

Summary

1. There is a wide variation in the physiological effects of various operations for duodenal ulcer.

2. Recurrent ulceration, one of the most important complications of the surgical treatment of duodenal ulcer, does not occur if achlorhydria is present in the fasting stomach, following a potent food stimulus and after vagal stimulation as well.

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PROBLEMS FOR ORGANIZED MEDICINE*

— *Presidential Address* —

FREDERIC J. BURNS, M.D.

The Author. *Frederic J. Burns, M.D., President, Providence Medical Association, 1952.*

THIS TOPIC has been chosen in view of its ever increasing importance. It is a fact, that while great strides have been made in the organization of groups other than medical societies, the efforts in such lines by Organized Medicine have failed to parallel those of other groups. It has been said that medicine's attitude has been too placid. It too meekly acquiesces. The reason often given for its action is that "politics and business have no role in medicine." Gentlemen, they need not be practiced in medicine, but their results, relative to their effects on medicine, should be thoroughly evaluated. The force of Organized Medicine can be felt only if its ethics as a group, or that of any individual doctor, are above reproach.

Organized Medicine, as we know it, derives its name primarily from a scholastic background.

Socialized Medicine is a cosmopolitan structure composed of some few doctors, social workers, politicians, statisticians and theorists. To these the ever important relationship between the doctor and the patient means but little. The progress of Socialized Medicine parallels the widening of this breach.

It is evident that two distinct lines of thought exist.

The progress of socialism in medicine is aggressive, is persistent, and is unrelenting. We are often misled into thinking that it exists solely at a national level. Any doctor can, with a moment's reflection, recall ever increasing incidents that have widened the breach between him and his patient.

Against this progress, Organized Medicine, through the AMA, struggled at the national level to prevent further inroads. Their work was excellent and they are to be congratulated. However, it appears that a similar struggle faces the doctors in the communities.

At the district levels, Organized Medicine has faced its problems in an orderly and honorable manner. Granted, that is the desired approach. Also all should be appreciative of the men who have put much time and effort into the committees which handle such work, i.e. the Committee on Ethics and Deportment, the Committee on Public Relations, etc. Their work has been most commendable.

However, Gentlemen, let us evaluate what we ask these committees to do. We have asked them to face a formidable force. It should be accepted readily that a medical society is not equipped properly to face the array of talent with which it is to cope. Briefly consider them in general. There are the political problems; the problems of the press; the sick benefits and insurance relations that under salable promotion appear fine but in operation are often so unsatisfactory; the legal factors; and ad infinitum.

Review the practice of medicine in the past fifteen years and note that we have gained much from some policies. Yet look more closely and you are astounded by the amount of clerical work, the social service personnel, and the regulations that often are written in a wilderness of words that confront you in ever increasing amounts. Reference to the social workers is made with due respect to their excellent field. Reference is made to those who travel beyond the limits of their field. It is against the above impediments of good personal medicine that Organized Medicine has a duty to discharge.

It is relative to this duty that the following is offered for your consideration.

It is apparent that two choices remain open for Organized Medicine.

(a) The first is that it can maintain its present sincere efforts to present its side of the problem. However, judging from the well-organized forces behind the cradle to the grave philosophy, or from the salable arguments extended by those who attempt to prove that by percentages and statistics, all can enjoy good health, it appears that the persuasive efforts of Organized Medicine will be a poor second.

(b) The second choice would be to recognize the advantages that government resources can give to medicine, and to present the programs of Organized Medicine in such a manner that it will result in their acceptance.

If the second choice is the one employed, it per se necessitates some definite moves. It must be under-

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*Presidential Address to the Providence Medical Association at its 106th Annual Meeting, at the R. I. Medical Society Library, Providence, R. I., January 5, 1953.

stood that the judgment in the end will be passed by the public. Therefore, duly owed them are exact answers and explanations from Organized Medicine.

Thus, humbly I submit four norms that might initiate some positive action.

I. Frequently heard are derogatory stories relative to medical men who have assumed the responsibility in various fields, i.e., industrial, insurance, and health programs. If the accusations are true and some men are not fulfilling their obligations, the result is evident. The medical profession as a whole is burdened with the onus of the doctor who practices in such a way. It appears to me that Organized Medicine has a duty to discharge to the patients who would be treated under such circumstances. Thus I suggest that local societies establish an impartial credential board, listing their members who desire such practice, as fit or not fit for a particular type of work. To avoid criticism that politics within a society would allocate a member for a position, the advisory board should solely answer that the doctor is qualified or is not qualified in the opinion of the society for the specific work. They should categorically avoid recommending any one doctor.

II. Secondly, many complaints are heard concerning unsatisfactory pecuniary relations between a doctor and his patient, or between a doctor and i.e. an insurance company. If there are offenders on the part of the doctors in this phase, the patient or the insurance company should have a means of readily and easily presenting their problem for solution. Such a procedure should have strict uniformity. To gain such, I recommend that the secretaries of neighboring societies study in common this problem and second their recommendations to their respective societies. Unquestionably, Gentlemen, this entails much work. Yet, if the patients or other organizations have been abused, we should protect them. If their claims are false, they should be shown the error in their thinking.

III. When impartial examiners are employed by civic or business organizations, it should be mandatory that these men, duly accredited by the medical society, should maintain and practice their role as consultants in the full medical interpretation of the word.

IV. When the house is in order, welcome investigation. When properly organized the weight of medicine can be felt as a unit so that no law or regulation could be adopted to interfere with the proper personal relation between the patient and his doctor. Gentlemen, we have been honored to carry on a noble heritage. Let us be sure that those who follow us be as fortunate as we.

PHYSIOLOGICAL EFFECTS OF OPERATIONS FOR DUODENAL ULCER

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3. The only operations which can be depended upon to consistently produce achlorhydria under these circumstances are those involving resection of at least the distal one-half of the stomach together with the vagus nerves.

4. There appears to be a close relationship between the more serious untoward side effects of operations for duodenal ulcer and the size of the gastric remnant. The best clinical results are obtained by patients having the larger gastric remnants.

5. Since the physiological effects of hemigastrectomy combined with resection of the vagus nerves compare favorably with those following operations involving the removal of a larger portion of the stomach, and since the clinical results are superior, it would appear that this procedure is more likely to supplant subtotal gastrectomy alone as the operation of choice for duodenal ulcer patients requiring surgery than any other procedure we have studied to date.

6. A long follow-up of adequate numbers of carefully studied cases is needed to demonstrate the superiority of any given operation in the management of duodenal ulcer problems.

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PATRONIZE JOURNAL ADVERTISERS

WHY DETECTION CLINICS?*

ELMER FRIEDLAND, M.D.

The Author. *Elmer Friedland, M.D., of Buffalo, New York. Medical Director, Cancer Detection Center, Edward J. Meyer Memorial Hospital, Buffalo; Assistant Clinical Professor of Medicine, University of Buffalo.*

FOUR YEARS AGO, one of your most distinguished members, Dr. Herman C. Pitts, a former president of the American Cancer Society, addressed this conference on almost this same topic. He said then that after three years' experience of cancer detection centers in Rhode Island, it was still hard to estimate the value of such clinics. Other areas have had the same difficulty. In 1950 the California State Medical Society abandoned three of its four pilot centers. In March, 1952, the *Lancet* editorially deprecated their work, stating that the periodic examination of symptom-free people in the hope of detecting incipient malignant disease may be admirable in theory, but is too difficult in execution. *The Detroit Medical News* recently stated that the hopes for these clinics have not materialized. Yet, since Dr. L'Esperance founded the first one in 1937 in New York City, the idea has spread across the country, so that there are now over 265 detection clinics. Their popular appeal cannot be disregarded, but the medical profession generally is still skeptical as to their actual worth in the major fight against cancer. It may be possible, however, to resolve some of this controversy concerning the role of the cancer detection centers if we re-examine their proper purposes and functions.

The purposes of a center fall into three categories: clinical, educational, and investigative.

TABLE I

Purposes of Cancer Detection Center

A. *Clinical:* To provide a complete thorough physical examination for apparently well persons to:
   1. Detect asymptomatic early cancer.
   2. Detect precancerous lesions.
   3. Discover early manifestations of other diseases and health defects.

B. *Educational:* To promote preventive medicine by:
   1. Demonstrating value of periodic health examinations.
      a. Indoctrinate public to seek them.
      b. Stimulate doctors to offer them.
   2. Training in cancer examination—to physicians, medical students, nurses, etc.

C. *Research:*
   1. To collect statistics for scientific analysis.
   2. To evaluate methods of cancer and other disease screening which can be applied by any practitioner.

A. CLINICAL

For many years the medical profession has advocated periodic routine physical examinations to prevent disease and promote individual health. To this idea of preventive maintenance, so widely accepted in industry, the public generally has been apathetic. Recently though, its attitude has been changing, partially because of our efforts, but probably due mostly to the public education conducted by the American Cancer Society. Many of us may have deplored the "scare" element in their nationwide campaigns, but it has been a tremendous stimulus to cancer work. Periodic check-ups have become popularized when offered as a measure of protection against this dread disease. The mushroom growth of the so-called cancer detection centers has resulted from the public demand for such service, plus the recognition that asymptomatic lesions in accessible sites can be discovered early enough to justify hopes of increased numbers of cures.

TABLE II

Most Frequent Reported Sites of Cancer

Rates per 100,000 pop.—upstate New York

Organ	*Incidence*	*Mortality*
1. Breast	30.6	17.8 (3)
2. Skin	27.8	.....
3. Intestine	22.9	20.6 (1)
4. Stomach	17.7	18.6 (2)
5. Cervix uteri	13.9	7.8 (7)
6. Prostate	12.7	9.2 (6)
7. Rectum	12.6	9.4 (5)
8. Lung-bronchus	10.6	12.1 (4)

continued on next page

*Presented at the 5th Annual Cancer Conference for Physicians, under the auspices of the Rhode Island Medical Society, at the Memorial Hospital, Pawtucket, R. I., October 15, 1952.

Six sites of cancer origin—cervix uteri, lung, rectum, breast, oral cavity and skin—account for nearly 50% of cancer mortality in women and 25% in men. In these sites, lesions can be discovered when small and asymptomatic and at that stage have a high rate of curability. Statistics of the actual incidence of cancer compared to deaths disclose the greater number of malignancies that could be diagnosed earlier.

The most frequent sites, according to deaths, are: Intestines, stomach, breast, lung, rectum, prostate, and cervix uteri, while, according to reported cases, the order of frequency is: Breast, skin, intestine, stomach, cervix, prostate and rectum.

Westing gives figures for the percentages of fatal cancers that could be picked up by routine examinations:

TABLE III

% of Fatal Cancers Discoverable (Westing)

Physical examination and routine lab.	30–40%
Laryngoscopy adds	2%
Chest x-ray adds	10%
Proctosigmoidoscopy adds	4%

Now what is a cancer detection center? It is a quasi-public subsidized clinic in which presumably well persons are given a screening type of examination, with especial emphasis on the discovery of unsuspected asymptomatic cancer and precancerous conditions. Although there is wide variation in the scope of their work, most centers follow the recommendations of the American College of Surgeons and perform a thorough physical examination on a limited number of individuals. In addition to the "routine" laboratory tests, most include a chest film and vaginal smears, while some do G.I. x-rays and surgical biopsies. The examinees—they are not patients, since no therapy is given—are mostly self-referred. If further diagnostic procedures are deemed necessary or if pathology is found the examinee is always sent back to his own physician.

As an example of a fairly typical small detection center, I would like to cite the experiences after four years of operation of the one at Meyer Memorial Hospital in Buffalo. It functions as a separate unit, with a budget derived from fees, aid from the New York State Health Department, and a subvention from the local cancer society. It operates two evening sessions per week, examining 15 to 16 persons each time. It is staffed by certified specialists in four divisions (EENT, Internist, Surgeon, Gyn.) who take a brief functional inquiry and perform a complete physical examination. Sigmoidoscopy will soon be added to the routine. Laboratory work includes: chest x-ray, Wasserman, urinanalysis, hemoglobin, white blood count, differential blood smear, stool for occult blood, and vaginal and cervical smears. Cervical biopsies are taken if any abnormality is seen there. The examinees are later given verbal reports and recommendations while complete written summaries are mailed to their private physicians. Since it is the only such center in a community of 800,000 people, we regard it chiefly as an educational rather than as a service project. Therefore, repeat examinations are not done, but the examinees are urged by follow-up letters, to obtain their annual check-ups from their own doctors. It is always stressed that the private physicians can do exactly the same type of examination.

TABLE IV

Number Persons Examined

Year	*Men*	*Women*	*Total*	*% Without Private M.D.*
1948-1949	363	939	1302	18.4%
1949-1950	350	941	1291	27.8%
1950-1951	363	970	1333	27.4%
1951-1952	348	981	1329	23.02%

Age Distribution: Majority between 35 and 50 years of age.

Note the preponderance of women, although cancer incidence is about equally divided between the sexes (greater egotism of men?)

TABLE V

Cost of Individual Examination

	1949-50	*1950-51*	*1951-52*
Average gross cost	$23.50	$21.97	$22.62
Average fee paid (Top charge $10)	9.55	9.57	9.55
State Health Dept. contrib.	8.33	8.01	8.12
Cancer Society contrib.	5.68	4.39	4.95

Most centers cite a cost of from $7 to $15 per examination, but they often fail to include services supplied by other agencies—hospital, laboratories, health departments, et al. We feel that ours represents more accurately the true cost of a good examination since it contains all expenses—equipment, supplies, salaries of all personnel, insurance, laboratory, etc. It demonstrates that such clinics are feasible for the entire population only at costs comparable to private medicine unless they are subsidized. The chart also shows that the type of people attracted to the centers are most often those who could afford to pay for similar services privately.

TABLE VI

Summary of Conditions Found

	1948-49	*1949-50*	*1950-51*	*1951-52*
Cancer	7	7	11	9
Suspicious of cancer	23	29	27	26
Precancerous	.....	352	387	373
No pathology	150	148	129	110
Add'l. exams rec.	477	424	324	243
Treatment rec.	804	773	779	814
Total path. cond. found	2638	2801	3504	3282
Path. conditions per examinee	2.03	2.17	2.63	2.47

TABLE VII

CA. Detection Rate

Year	*No. exam.*	*No. ca.*	*Rate*
1948-49	1302	7	.54%
1949-50	1291	7	.54%
1950-51	1333	11	.82%
1951-52	1329	9	.68%

TABLE VIII

CA. Found (32 in 5255 examinees)

8 Cervix	1 Prostate
8 Breast	1 Floor of mouth
2 Rectum	1 Hypernephroma of kidney
2 Lung	1 Carcinomatosis
2 Chronic lymphatic leukemia	2 Epithelioma
1 Sigmoid colon	1 Hodgkins
1 Stomach	1 Retroperitoneal fibrosarcoma
1 Thyroid	
1 Ovary	

TABLE IX

Examples of Precancerous Lesions Found

	1948-49	*1949-50*	*1950-51*	*1951-52*
Solitary thyroid nodules	12	18	16	15
Breast nodules	48	44	35	12
Cystic mastitis	95	73	46	20
Leukoplakia oral	2	6	5	12
Cervicitis	199	156	230	189
Kraurosis vulvae	.....	1	5	2
Keratoses	8	4	9	5
Rectal polyp	3	2	5	7

TABLE X

Examples of Other Significant Pathology

	1948-49	*1949-50*	*1950-51*	*1951-52*
Diabetes, new	13	12	8	18
Substernal goiter	3	3	1	5
Nodular goiter	13	21	22	13
Poss. peptic ulcer	24	28	29	47
Hernias	74	50	66	42
Hypertension	123	90	127	89
Obesity	93	96	113	143

B. EDUCATIONAL

Professional education at the Meyer Hospital Detection Center is limited by its size, but has been correlated with other organized cancer instruction. Senior medical students and groups of doctors and nurses attending cancer courses visit the Center as observers. Occasionally, local physicians come to study a particular technic, such as the taking of vaginal smears or cervical biopsies.

Public education is also limited in numbers, but fairly effective in scope. The examinees learn that there are no special tests nor machines for the detection of cancer, while the discovery of other conditions serves to impress them with the importance of a thorough physical examination. For many persons, it is the first experience with the procedure, and the pattern set may help to influence local medical standards. People who cannot wait for a clinic appointment or are not eligible are informed that any good doctor can do the same work. A year after the Center visit, the examinee is sent a letter urging him to have a repeat examination by his own physician. Thus, the Center acts as a focus to spread the doctrine of periodic health check-ups.

As noted above, almost a quarter of our examinees have no personal physician. Our recommendations send many patients to doctors for more extensive procedures, treatment or repeat examinations and thus promote individual preventive medicine. Statistics on this are not yet available, but the impression from our follow-up routine in the more serious conditions uncovered is that in a large percentage these recommendations are carried out. However, Fremont-Smith in this week's *A.M.A. Journal* quotes a New Orleans Center where 60% of a small group referred to their own doctors for further examination did not get it.

C. RESEARCH

I. *Statistical* (Analysis of results to date):

1. It has been demonstrated that cancer *can* be picked up in presumably well people. Experience at pilot centers, varying with the age groups covered, the acceptance of persons with symptoms and the scope of the work, found cancer in from 0.5% to 1.5% of examinees. In a recent study of 52,000 examinations in 90 detection clinics, the rate was 8 per 1000 (0.8%). In addition, about 15% have precancerous lesions, and another 30% have other diseases or defects requiring treatment.

2. *Age:* Examination of patients under 35 years gives too low a yield from the practical point of view. Enough cervical and breast lesions are found, however, to justify starting at age 35 in women. For men, 40 years is the suggested minimum.

3. *Sex:* Our figures show that men particularly need stronger motivation to undergo physical check-ups. National statistics point out that cancer mortality has reached a plateau in women, but is still rising in males.

4. *Publicity:* Questioning of examinees in our Center reveals that newspapers and word of mouth are the prime avenues for public education in this regard. Television may be of greater importance in the future.

II. *Evaluation of Methods*

As Dr. George W. Waterman, our chairman today, suggested in 1948, the chief function of the detection center may be to evaluate procedures and tests to determine the best type of general cancer examination which is utilizable in a general practitioner's office and is available at reasonable cost.

continued on next page

1. *History:* Self-screening questionnaires such as the Cornell Medical Index, take too long for the doctor to read. A simple system inquiry, as done at the Meyer Hospital Center during the course of the examination, is quite effective in furnishing clues for further studies.

2. *Physical Examination:* A good routine can be done by any physician. Laryngoscopy is easily learned and should be done on every patient with hoarseness or cough. Methodical breast palpation and instruction in self breast examination will double our present low cure rate of 38% for mammary cancer. Vaginal inspection in older women is facilitated by use of the Pederson speculum.

3. *Procto-sigmoidoscopy* is of great value and utilizable by any doctor. V. T. Young in 500 asymptomatic patients found cancer in 1% and rectal polyps in 8.8%. Christianson and Tenner found 274 adenomas in 2226 patients over 45 years of age (12.3%).

4. *Laboratory tests* need not be elaborate. A syphilis test, urinanalysis, hemoglobin, and white blood count suffice. Routine differential smears give little information in well persons, but can be done if indicated. The sedimentation rate is of some limited value if done in the fasting state and if other disease is excluded. A finger cot specimen is quickly tested for occult blood, but our results have given too few positives in routine screening.

5. *Vaginal smears* have been highly regarded as a screening measure for cervico-uterine cancer, but from experience at our center, doing vaginal and cervical smears in 2850 women, in only 2 cases were the smears independently positive, that is, where no lesion was seen. More frequent use of cervical biopsy, plus diagnostic curettage in cases of abnormal bleeding, has been much more productive.

6. *Chest x-rays* are available economically in most communities. Annual or in men over 50 better semi-annual chest films should increase the now depressingly low number of lung cancers found at a time when resection can be performed.

7. *G.I. X-rays:* The high cost of the procedures and the shortage of radiologists militate against their routine use. In many studies, using either complete G.I. series or various shortcuts, the barrenness of the results has revealed the impracticality of mass screening. In one group of 1576 G.I. series, only 3 tumors were found. In the latest survey, by Morgan and his group using the Schmidt photofluorographic camera at Johns Hopkins Hospital, 26 cancers were picked up in 10,000 dispensary patients, with a negative error of 9%; each examination cost betwen $4 and $5 or $2000 per gastric cancer found.

8. *Newer technics* in cancer diagnosis are being investigated in other clinics. Papanicolaou smears of stomach cells brought out by a corrugated gastric tube show great accuracy, but the method is cumbersome. Segal of Rochester, New York has introduced a method of tubeless gastric analysis; exchange ion resins are swallowed and the urine subsequently tested for a quinine indicator which tells the presence or absence of free hydrochloric acid. Patients with achlorhydria can then be subjected to x-ray study. Some centers are also experimenting with various biological or physio-chemical tests for cancer; so far these are non-specific and of no real value.

The deficiencies in the operation of a cancer detection center are apparent from the figures cited earlier. Among them are:

1. *Low coverage:* At 15 per session—the average in most clinics—only a minute segment of the community can be covered. However, as an educational demonstration, it is considered more important to examine carefully a small percentage than to attempt to survey a large number quickly and inadequately.

2. *Limitations of facilities:* Regardless of how much detection center facilities would be increased, it is at present impossible to screen the entire population of the cancer age. In upstate New York, for instance, there are 2,700,000 persons over 40 years of age. In Rhode Island you have over 800,000 people with about 1000 doctors to perform all medical services. Centers that perform repeat annual or semi-annual examinations soon load up and find themselves supervising the health of a small group at the expense of the whole community.

3. *Long waiting periods before examination.* Inevitable, but with good publicity and an alert local profession, many of the applicants could be referred to private physicians.

4. *Limitation of the examination:* One of the big problems is to determine how far to go in looking for disease. Within the limitations of time, space, personnel, and money, practical limits must be set to the completeness of the job.

5. *Difficulty in restricting the clinics to asymptomatic persons:* But almost everyone in the cancer age group has some symptoms if an adequate functional inquiry is done. Also symptoms or disease related to one organ do not preclude the presence of asymptomatic cancer in another site.

6. *Difficulty in followup of suspicious lesions:* The same difficulty is often found in regular private or hospital practice. Much depends upon the patient's personal physician. We have found that letter reminders to the examinee are often productive in sending that person to a doctor for care.

7. *False sense of security by examinee:* Undoubtedly true, but at least the people have had the benefit of a complete physical. In our clinic, they are told of its limitations in the application blank and at the summary interview by the medical director.

8. *High cost per case of cancer found:* This may be from $3000 to $3500. Against this, it is estimated that the care of an advanced case, requiring extensive surgery and prolonged hospitalization, will cost the patient, his family, or the community, an average of $3500. The other aspects of the detection center must also be weighed in this balance.

There are other arguments, many quite valid, for and against the basic idea of detection centers. Some of these are:

1. *Small percentage of Cancers found:* This low "yield" is inevitable because of the type of patient material. Then, too, in some suspected cases, further diagnostic procedures are not carried out or the definitive diagnoses may not be reported back. Of importance, also, is the detection of precancerous conditions—cervicitis, rectal polyps, keratoses, etc.—and from the standpoint of general health, the discovery of other disease states.

2. *High cost of operation:* Ackerman declared in 1947 that "without disrobing the cancer detection clinics of the nobility of their aims, it may be justly considered whether the effort and expense cannot be put to better service in increasing and sponsoring facilities for the training of specialists (tumor pathologist, radiotherapists, and surgeons) on the skill of whom the therapeutic results will greatly depend." I concur heartily with this thought, but the public is now contributing funds enough to aid all parts of the cancer control program.

3. *Inability of yearly examinations* to aid materially in the early diagnosis of silent cancer, because:

a. Relatively elaborate examination necessary. True, but attempts to simplify it or restrict it to certain sites seriously decreases its educational value.

b. Relative crudeness of our methods of diagnosis. But until medical science can develop a biologic test comparable to that for syphilis, the physical examination, with other tests added as indicated, is the only program now available.

c. Patients might delay care of a complaint to await time of annual check. All cancer publicity warns people to see a doctor at once for any suspicious symptom.

d. Cancer can develop in the intervals between examinations. Kirklin states, for example, that really to detect early gastric malignancy, x-rays should be done every 3 months. There must be, however, practicable limits and the annual recheck is the most feasible.

4. *Inability to detect cancer in inaccessible sites.* It is argued that no matter how well organized or medically efficient the detection clinic be, there is little it can offer at this time to the person with an early cancer in an inaccessible organ. This is true even though at times examiners at our center have picked up hints which have led to the diagnosis of hidden cancers (e.g. of the kidney, ovary, colon). Our efforts are aimed at the 50% of fatal cancers that arise in accessible areas.

5. *Cancerophobia:* The centers alone do not create it and often help to allay it. As the second leading cause of death, cancer deserves great respect. If it were not for the fear of this disease that brings the public to these centers, the many other conditions (15% precancerous lesions, 30% other conditions requiring treatment) would not have been uncovered.

6. *Invasion of private practice,* because:

a. Patients are admitted without referral.

b. The public may think a clinic is more competent than the private doctor.

c. Accustoming people to attend any type of clinic is another entering wedge for socialized medicine.

d. There is actual competition with the practitioner. Admitting some truth to these charges, if the public demands these centers, it is preferable to have them under semi-private professional supervision than as state supported units. So far, unlike many "welfare" projects, the cancer detection center, when properly run, creates demand for new services rather than lessening private medicine. When a potential private patient in presumably good health goes to the center, if no pathology is found, the doctor has lost little, since too few persons yet go to practitioners for routine examinations. On the other hand, the center sends many patients to doctors for more extensive procedures and treatment, and encourages people to visit their physicians for repeat annual physicals.

7. *Use of center to check up on private practitioner:* In the Meyer Hospital Cancer Detection Center, study of followup reports show that this actually does not occur with any great frequency, and has not hindered our good relations with the profession locally. Some patients and doctors also mistakenly consider the center a free diagnostic clinic and are therefore disappointed.

8. *Referral back to "inferior" care:* Detection Centers have occasionally been criticized for employing "high-powered" specialists as examiners

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and then referring the examinees back to general practitioners, who might not carry out the recommended procedures. We feel that the private physician should best be able to judge what to do for or where to send his patient.

9. *Alternative programs* have been advanced:

a. *The 5-point cancer detection examination:* The low coverage and small cancer yield of the centers have led Ayres (1949) and others to the opinion that a more practical approach would be a screening of every adult over 40 years of age by a simple physical examination for tumors of the five common accessible sites (skin, lips and oral cavity, breast, pelvis, and rectum.) This involves no expensive laboratory work, x-rays, or special procedures, and could be done quickly and economically in every doctor's office. This 5 point examination is being tried in Hillsdale County, Michigan, and offers much promise. It is not a substitute for a comprehensive health examination and may fail to satisfy the conscientious physician or the educated public.

b. *The multiphasic screening program* sponsored recently by the Public Health Service. These attempt to screen large masses of people for a number of diseases simultaneously by mechanical means. The low expense given ($1.51 in Atlanta, Georgia) is not, I believe, all inclusive, and they possess a great potential for giving a false sense of security. While of some value for picking up syphilis, tuberculosis, and diabetes, the detection of cancer still requires the services of a physician.

CONCLUSION

The slogan "Every doctor's office a detection center" has been a popular one, but one not often realized. Comments from many examinees at Cancer Detection Centers reveal that too many private practitioners are too busy, too lazy, or too indifferent to conduct thorough physical examinations. This failure to meet the increasing public demand for such services, plus the more attractive motivation by a clinic which offers a measure of protection against the number two killer, has led to the growth of this type of subsidized clinic.

The discovery of a few early cases at rather high cost in a detection center may be of little aid in the major fight against cancer, but its greater influence is to demonstrate the importance of complete periodic health checks, to interest the public to request them, and to stimulate physicians to provide them. In this way, such services can be made available to all the people, and the possibility of doubling the number of curable cancers discovered can be attained. The cancer detection clinic may then be continued properly only in large centers as an experimental and education project.

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OUR SOCIETY'S LEGISLATIVE PROPOSALS

THE ACTION of the House of Delegates of the Society in voting to introduce legislation in the General Assembly to improve the workmen's compensation law as regards its medical phases, and also to submit an amendment to the temporary disability compensation law to permit the administrator to make available confidential information to a committee of the Society for better operation of the program, certainly reflects the general opinion of all physicians.

For years the workmen's compensation statutes have been subject to study and review. The Society through its committee on industrial health in particular, has cooperated in every way possible to bring about improvements. Twice the Society has adopted amendments that it felt would improve the statutes, and twice it has been before State study commissions to offer its full cooperation to effect better medical provisions in the act. No legislative action has been successful.

Now the House of Delegates has voted that the Society shall sponsor these amendments of its own accord, and it is to be hoped that the desire of the medical profession to promote this particular phase of the legislation may be supported by the Assembly, and that thereby other groups in the community may be encouraged to strengthen other phases of the law. The amendments submitted by the Society are those which won approval from the study commission three years ago.

The temporary disability act amendment proposed by the Society would be merely permissive legislation, allowing the administrator to make any record, report or other information available to an advisory committee named by the Rhode Island Medical Society for the purpose of considering medical phases relative to the administration of the act.

For years the Society has aided this state disability program with an advisory committee. However, by law the administrator is prevented from giving out complete information, thus preventing a review of all facts of a medical problem involving a physician and his patient, and often sending such cases through a lengthy trial by appeal when the matter might have been adjudicated by the administrator guided by counsel in part from the medical society's committee.

The introduction of legislation is fraught with the danger that its intent will be misunderstood, and that the right of amendment by others may destroy the true value of the original proposal.

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The Rhode Island Medical Society has taken its latest steps regarding amendments to the statutes solely to improve the legislation in the best interests of the people of this State and for better administration of the particular statutes. It accepts responsibility only for the proposals it has advanced, and it certainly has every reason to request that its efforts not be sabotaged by any selfish interests.

The proposals seek for better administration of medical problems involving the people of Rhode Island. On such grounds alone should they be judged.

WALTER C. ROCHELEAU, M.D.

It is inevitable that from time to time a note of sadness must appear in this section. On the morning of December 25, 1952, a long and distinguished career came to an abrupt end. With a feeling of deep regret and heartfelt sympathy, we dutifully signalize the death of one of our past presidents, Dr. Walter C. Rocheleau.

True to the noblest ideals and traditions of the medical profession, he fulfilled religiously and with charity his duties and obligations. For more than forty years Dr. Rocheleau gave unstintingly of his time and efforts with complete disregard for his own health.

During these many years he prized his membership on the Woonsocket Hospital Staff and was always a very interested and enthusiastic member. At various times he served as chief of the department of surgery, president of the Staff, member of the Medical Board and member of the Board of Trustees. Always alert and receptive to progress, he was ever the prime mover and stimulator of many beneficial changes and improvements.

As a member and past president of the Woonsocket District Medical Society, he was faithfully present for the meetings and indulged actively in all the deliberations.

His interests and efforts were not confined solely to his community. Ever zealous and concerned for his responsibilities, he brought integrity and sincerity to all of his affiliations and they in turn profited from his talents. During the long span of his activity he considered it to be a scrupulous duty to attend the meetings of the Rhode Island Medical Society, and he tried to awaken the same interest in fellow members. Recognizing his merits and ability, he was elected president of the Rhode Island Medical Society and served for the term of 1937-38.

His wise counsel and surgical competency stood out pre-eminently and his help was sought by his fellow practitioners and patients alike. His was a most completely illustrious and distinguished career. His community, his profession and the Rhode Island Medical Society have lost a valued member.

PROVIDENCE MEDICAL MEETINGS

The Providence Medical Association, our largest district society, is certainly to be commended for the excellent meetings it has conducted the first Monday of each month to which all physicians in the State have been regularly invited. The core of our medical organization is the district or county unit, and its successful development sets the pace for an effective and progressive statewide society of benefit to all physicians.

During the past year the Providence Medical Association has gone far beyond the confines of this area to select outstanding speakers to present scientific lectures. The attendance has been satisfactory when one considers the continuous round of meetings and allied activities to which most of us are subject week in and week out. The Association opened its 1953 year with Dr. Francis Moore of Harvard as its guest lecturer, and this month had as a guest speaker, Dr. Melvin Casberg, Chairman of the Armed Forces Medical Policy Council, who discussed "Medicine at the Department of Defense Level."

For years the Providence Medical Association has contributed liberally from its income to support the Medical Library and to purchase medical journals. This contribution is for the benefit of all physicians in every area of the State. Now the Association has made an appeal to those doctors who are not active members to accept associate membership which is open to any member in good standing of any district society other than Providence. The small dues assessment of five dollars will be more than repaid by the excellent lectures sponsored by the Association.

We urge every doctor outside the Greater Providence area to consider favorably the invitation to become an Associate Member of our largest district society.

AMA DUES

This month the membership has been sent notice of the annual assessment of dues to the American Medical Association. These dues are payable to the AMA, but must be transmitted through the central office of the Rhode Island Medical Society in order to establish the eligibility of membership.

AMA dues are to be paid by June 1 if a member wishes to retain active membership in the Association. With the scientific meeting in New York City this year, starting June 1, it is highly important that our membership clear this account as soon as possible in order to be eligible to attend the many sessions the first week in June.